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SYDNEY: SATURDAY, AUGUST 27, 1921.

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A few years ago the Research Commission of the National Dental Association of America produced evidence which seemed to prove that infections at the roots of pulpless teeth could be carried through the blood stream and cause systemic disturbances.

The result of this Commission so agitated the minds of the medical and dental professions that our journals were soon full of papers dealing with the necessity for extracting all pulpless teeth and so overwhelming was the evidence produced that a large percentage of practitioners not only advocated, but carried into effect, this extreme measure.

The American mind was so obsessed with the possibility of septic foci at the root ends of pulpless teeth that, during 1917, 1918 and 1919, it became quite the custom for old and young to subject themselves to the radical treatment of extraction; it is safe to say that more dentures were inserted during those years than for years previously. However, during the past months an alteration in mind has come about and a better balance has been established.

Now, it is true that some patients with systemic infection have improved upon the removal of the pulpless teeth, but it is equally true that a large percentage of systemic infections do not improve after such teeth are removed. We are able to record, not only improvement, but decided cures in such cases as rheumatoid arthritis, iritis, neuritis, endocarditis, etc., but ye that does not necessarily prove that the systemic infection was caused solely by the septic foci at the ends of the pulpless teeth, for there is no proof that the infection of the teeth was the only infection present in the body. Sometimes an improvement is due to the alteration in the change of balance between the number of micro-organisms which the leucocytes and the system can take care of; sometimes pulpless teeth are the direct cause, or, if not solely the direct cause, at least the predominating cause and removal of them brings about a definite and speedy cure. We have all had such cases and results. The question then, "Are all pulpless teeth to be extracted?" may be answered at once with the remark that it depends on the condition of the pulpless teeth. For the sake of brevity I have divided them into three classes, particularly from a radiographic point of view:

Class (i.): Pulpless teeth which have not received treatment.

¹ Read at a Meeting of the New South Wales Branch of the British Medical Association on May 27, 1921.

Class (ii.) : Pulpless teeth with roots apparently filled completely, yet radiographically only partially filled.

Class (iii.) : Pulpless teeth with roots completely filled and radiographically "checked up" as normal.

Class (i.), that is, pulpless teeth that have not received treatment, generally comprise those which have lost their pulp tissue, either by (1) traumatism or (2) oral infection due to the processes of caries. Pulp that die through traumatism, *i.e.*, some sudden shock cutting off the blood supply (especially in anterior teeth), show radiographically well marked diffuse pathological areas at the apices of such teeth. These respond quickly to treatment, mainly because oral infection has not entered the root canals, a subsequent X-ray examination revealing healthy cancellous tissue.

Pulpless teeth, due to the action of caries, do not always respond to treatment. Pulpless teeth are wrongly called "dead teeth"; they are not dead teeth, because, although the tooth has lost its pulp tissue, which supplies nourishment to the dentine, yet the outside membrane is alive and receives its nourishment from quite a distinct source.

Skiagrams of untreated pulpless teeth reveal the well-known abscesses or granulomata at the root ends.

When it has been found that a given tooth has a granuloma, it becomes our duty to extract, as we cannot be sure of any known method of getting rid of the adherent mass (which is almost always associated with streptococcal infection), except by the operation termed apicoectomy, which is the amputation of the root end after penetration of the alveolar process. This operation is usually confined to anterior teeth.

Granulomata are progressive in character and old-established ones, as well, of course, as the so-called acute alveolar abscess, perforate the alveolar wall with a fistulous tract and thereby establish drainage. When a sinus is present, successful treatment becomes a possibility.

Class (ii.) : Pulpless teeth with roots apparently filled completely, yet radiographically only partly filled. Before the discovery of Röntgen rays, if a dental surgeon, after filling the root canals of any tooth and finishing off with some suitable filling material and thereby affording complete comfort to his patient, had been told that the root canals were not properly filled, or that there was a rarefying area or granuloma at the apex of such a tooth, I am afraid that his language would have been more emphatic than polite. Yet we now know that, notwithstanding all the care and skill that it is humanly possible to put into such work, it is just as likely as not, after having the work checked by X-ray examination, to find it somewhere defective. The skiagram has, therefore, become a most valuable addition to the dentists' armamentarium and must be continuously used if we are to carry on our work on a scientific basis.

Rarefying areas and granulomata are the direct result of micro-organisms, not only from the oral cavity, but also from the blood stream and lymphatics. Now, the reason organisms live in root canals in spite of treatment, is mainly because we are not in

possession of a drug that has selective action to destroy them. All the drugs at our command in destroying organisms also destroy tissue cells; it consequently becomes difficult to state whether rarefying areas found at the root ends are due to infection or to drug destruction or to both. And until we discover such a drug as salvarsan is to the spirochæte, we must expect the percentage of failure as I have stated. The dental profession throughout the world is in search of a drug with selective action and one that will not discolour tooth structure. At the present moment, chlorine suspended in an oleaginous base or a solution of silver nitrate is used as a root canal germicide and zinc oxide, incorporated with thymol, mixed into a paste with eugenol, is an example of an ordinary root canal filling.

It is the experience of dental practitioners to find that the X-ray specialist determines that teeth are partially filled or imperfectly filled when they are in reality completely filled, but with such a substance as I have stated, which is radiolucent.

The addition of bismuth oxy-chloride would render the root filling opaque and would prevent the radiologist making this mistake. The clinical history and radiographic report do not always agree and, as a matter of fact, it is unwise to give an interpretation of a radiogram without having the clinical history.

Many of the so-called rarefying areas at the apices of teeth are due to thinning of bone and are not visible in skiagrams taken at another angle and many of the unfilled roots are either vital teeth or teeth filled with radiolucent material. There is also a percentage of root canals not filled exactly to the apex and the fault of this often times is with the patient, who does not see the necessity for paying for radiograms when comfort is established. Education along these lines becomes obligatory.

"X-ray examinations, although a great aid, are also a great menace. Never has a greater boon been given to dentistry than this and never has a worthy method been put to more ignoble uses. It showed us the limitations of our pulp canal work; it exposed the discrepancies between what we should do and what we did do. It showed us the impossibility of doing some of the things we tried to do and altogether it gave us a greater insight into and a better perspective of the result of our technical procedure, it awakened in us a new conscience and stimulated us to do better work. We are indeed its debtor in an immeasurable degree in these various respects. It also showed us the ravages of absorption in the bone around root ends and furnished the means of investigating conditions which previously had been a sealed book.

"But it has misled us in some respects, *viz.*, because of faulty interpretation and because of its limitations as a discloser around root ends. Immediately and quite naturally the medical and dental professions jumped to the conclusion that any shadow in a radiogram at the apex of the tooth meant an abscess or an infection. Some of them undoubtedly did; but in many of these cases it was quite impossible to say whether a shadow meant an abscess or whether it was simply a thinning of the bone from some absorptive process that may have occurred years previously

and was not associated with any infection whatsoever. The radiogram shows merely different degrees of density; it does not show pus nor demonstrate infection; the sooner this is recognized the better it will be for our patients.'

Class (iii.): Pulpless teeth with roots completely filled and radiographically checked up as normal. It is pleasing to relate that, so far as our present knowledge goes, at least 80% of all modern root fillings are not only clinically, but are also radiographically, correct. These treated teeth continue as normal and radiograms do not reveal any pathological areas. It is safe to assume that pulpless teeth may be retained wherever they are amenable to treatment. Most pulpless teeth (excluding those with definite granulomata) are amenable and therefore may be retained.

To my mind, there are two distinct phases of auto-intoxication from teeth: one from pulpless teeth as I have described in Class (ii.), which can be termed a focus infection or an extra-apical infection; the other arises from and around the gum margins of teeth, commonly termed *pyorrhæa alveolaris*, which can be regarded as a septic absorption. Of these two classes, it is the opinion of most dental practitioners that *pyorrhœa* plays the more important part in regard to systemic disturbances. Amazing results are often established by cleaning up the pyorrhœal conditions. *Pyorrhœa* can be cured in its early stages, that is, when the disease has not progressed so far as to infect the alveolar process and produce the loosening of the teeth in their sockets. Success in treating this more advanced form of *pyorrhœa* depends (1) on the absolute removal of all calculus from the root surfaces by surgical curetting, (2) by establishing immobility of the teeth in order to allow of bone and tissue regeneration. Drug treatment in early and advanced stages can be availed of.

As an example, recently in one case the organisms of Vincent's angina, together with the fusiform bacillus, were found. A solution of salvarsan was applied locally with excellent results.

In a second case *Amœba histolytica* was discovered at the bottom of the pyorrhœal pockets. Emetine hydrochloride cleaned up all suppuration. Again, in a third case a mixture of a streptococcus, staphylococcus and *Micrococcus catarrhalis* was present and is still present, despite curettage and the frequent use of Dakin's chlorine solution. Unless the patient is suffering from a definite toxæmia, it does not become us at once to advocate extraction; much depends on whether the suppuration can be cleaned up or not.

No doubt it would surprise the majority of the members of the medical profession to hear it stated that pyorrhœal pockets are almost ever present in adults' mouths from middle age and onwards. Would the members present be satisfied to have all their useful, yet pyorrhœal, teeth extracted? I think not. We know the limitations of our plate work and for that reason we feel that our policy should be to "hasten slowly" before we condemn pyorrhœal teeth and teeth with doubtful shadows at their root ends.

We know that one small shadow in one case can be so virulent as to produce alarming symptoms, whereas in another the presence of a dozen or more large rarefying areas cannot be determined by any

means at command, except by X-ray examination, and no systemic infection can be discovered.

We do not think that all the physical ills that are attributed to teeth are of dental origin; neither do we think that the dentist holds the key to almost universal good health. The practice of some physicians of the present day in sending their patients to the radiologist for dental films and relying on the radiologist's diagnosis, without consulting the patient's dentist, is to be severely condemned.

To summarize: Oral prophylaxis for the prevention of decay and pyorrhœa encroachment is of such vital importance as to demand the attention, not only of the medical and dental profession, but of all people.

Pathological areas and pyorrhœa should receive our earliest attention. Eradication, either by treatment, or, if not expedient, by extraction should be our aim.

There is no more interesting or profitable field of collateral study for the physician than that of problems of the development of the teeth as portrayed by modern dentistry and I believe the dentists will find equal satisfaction in a survey of the changes in the body resulting from disease, the cause of which often finds expression in the changes in the teeth.

Frank and friendly discussion and exchanges of ideas between the two professions, such as this, will lead to a better understanding of the problems of each by the other and will render more effective efforts to prevent disease and to alleviate suffering.

INTRAVENOUS INJECTIONS OF ANTIMONY TARTRATE IN THE TREATMENT OF BILHARZIOSIS.¹

By Harold K. Pavy, M.B., B.S. (Adelaide),
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Introduction.

During the past six months at No. 7 Australian General Hospital, Keswick, I have had the opportunity of observing the effects of treating bilharziosis with intravenous injections of a solution of antimony postassium tartrate. In all ten cases were treated and the results and various examinations were tabulated and graphed as accurately as military conditions would permit. I propose to describe the method adopted and the effects and results of treatment and to show the individual records of each case.

The patients treated were not confined to bed nor dieted. Neither did they receive any other form of treatment before, during or after the injections. They were kept quiet or lying down for an hour or so after the needle; some did not even do this. Four were treated as out-patients and one man, who was the proprietor of a wood yard, came up for treatment in between delivering loads of wood. Several of the patients had rectal as well as urinary symptoms. The majority of the infestations were purely vesical as far as could be ascertained.

Method of Treatment. Solution.

The solution used consisted of 0.06 grammes (one grain) of tartar emetic dissolved in 5 c.c.m. of nor-

¹ Read at a Meeting of the South Australian Branch of the British Medical Association on July 29, 1920.

mal saline solution. Enough solution was mixed to last one week. It was kept in a small flask and sterilized and filtered immediately before use each time. A solution of antimony tartrate can be heated to 200°-300° C. without chemical change, so its sterilization is safe and simple.

Method.

This solution was injected slowly into a suitable vein well below the elbow joint with a 10 c.cm. serum syringe, the usual precautions being observed. An additional safeguard was the fact that the escape of the smallest drop of the fluid into perivascular tissues was accompanied by well-marked stinging. Using this as a guide, we are able to record that only three injections out of the 200 or more given caused any local symptoms and two of these occurred before we realized the importance of the stinging.

Dosage.

The initial dose in all cases was 2.5 c.cm. of the solution ($\frac{1}{2}$ grain tartar emetic). Patients who showed a good tolerance for the drug, were worked up to a 10 c.cm. (two grains) dose in four to six injections and kept on this dose with occasional remissions to a smaller dose. Others had to be worked up more gradually, but in all but one 0.12 grammie was given continuously for a considerable period. Doses of 0.18 grammie were given in two cases, but as the majority of the patients had moderately severe attacks of coughing with nausea and occasional vomiting after the administration of 0.12 grammie, it was not thought advisable to push the dose further.

Total Amount.

The average amount given was 1.8 grammes (27 grains). This usually meant that by the end of the course no ova were present in the urine for four weeks. The injections were given every other day at first, later on three days a week. The condition of the patient and the results of urinary examination were considered in determining the amount.

Duration of Treatment.

Active treatment occupied from seven to eight weeks and the patients were kept in Hospital for several weeks after the conclusion of the injections for observation. They were then discharged and instructed to report at intervals for re-examination.

Effects of Treatment.

(1) *Local.*—No local effects followed the injections unless some of the fluid escaped from the vein. The same vein could be used repeatedly. A severe local inflammatory reaction followed the escape of fluid into the tissue with acute pain and a hard, indurated, red swelling. Sloughing did not occur and the swelling ultimately disappeared, leaving no disability or sign of its existence.

(2) *General.*—Weight.—All the patients showed loss of weight during the course, most marked during the first week, i.e., after the first three injections. The greatest loss during this time was 1,814 grammes, the average just under 907 grammes. The weight results were not constant, three showing an initial increase, but in all loss of weight occurred during treatment varying from 450 to 3,600 grammes during the two months. After the initial loss of weight the tendency was to remain constant, or to

commence gaining weight; as soon as the course was completed weight was gained quickly.

Appearance.—With the exception of one patient all had thin, lined and usually pale faces. In four the complexion was decidedly muddy. This thin, lined expression was increased during treatment, but the face filled out rapidly after completion.

Loss of Strength.—Loss of strength and energy was complained of by several patients towards the end of the course. This we put down to the effect of the antimony. The patients were carefully watched and the dose reduced or stopped.

Anorexia.

Nearly all the men complained of loss of appetite and of the desire for food after the first month of treatment.

Pains.

Every patient complained at some time during the course of slight aching pains during the night following the injection, with a certain amount of stiffness of the muscles. The shoulder girdle was the site of election, especially on the side injected. The pains commenced after the patient became warm in bed and sometimes involved the whole body. Both the pains and the stiffness wore off an hour or so after getting up and moving about and completely disappeared after the cessation of treatment.

Temperature and Pulse.

In four cases a careful daily record of temperature and pulse was kept, taken before and after the injections. The temperature in all four cases kept remarkably constant at 0.5° C. below normal. The excursions of the temperature varied between 36° and 36.5° C. The pulse chart showed nothing abnormal.

Cough.

Every patient treated suffered from paroxysmal coughing immediately after injection. This was induced in several by the 0.03 grm. doses, but in the majority did not occur again till 0.09 grm. was administered. All coughed after the 0.12 grm. doses. One had such severe paroxysms that 0.15 grm. was the largest dose given. The cough usually commenced within a minute after the withdrawal of the needle and lasted from a few short coughs to a bout persisting for five minutes.

Vomiting.

Vomiting immediately after injection usually did not occur until the 0.12 grm. dose was given. Three patients vomited after the 0.06 grm. dose, but all were subsequently worked up to the 0.12 grm. dose without much discomfort. When the injection was given before meals, vomiting seldom occurred. One patient vomited on several occasions from three to five hours after the injection. There was a general tendency towards the end of the course for all the patients to be more or less nauseated after the injections; when this was marked the dose was reduced.

Eosinophilia.

One of the most interesting and constant features of the treatment was the rise in the percentage of eosinophile cells which occurred. At the first examination the percentage ranged from 2 $\frac{1}{2}$ to 16.5, the average being 8.5. In five patients there was an initial decrease in the percentage during the first

CASE I.

January 13, 1920.—The patient complains of terminal haematuria and pain in micturition. No blood has been passed in faeces. Urine: Ova, pus and blood are present. Eosinophile cells: 7%.

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
January 21, 1920	0.03	7%	Ova, pus and blood present	
January 23, 1920	0.06	—	—	
January 25, 1920	0.06	—	—	
January 27, 1920	0.06	5½%	—	
January 29, 1920	0.06	—	—	
January 31, 1920	0.06	—	—	
February 2, 1920	0.09	7%	Ova, pus and blood present	Severe paroxysmal cough
February 4, 1920	0.09	—	—	
February 6, 1920	0.09	—	—	
February 8, 1920	0.09	—	—	
February 10, 1920	0.12	—	—	
February 12, 1920	0.12	—	—	
February 14, 1920	0.12	—	—	
February 16, 1920	0.09	19%	No ova or pus; few blood cells	
	1.14			
February 20, 1920	0.09	—	—	
February 22, 1920	—	—	—	
February 26, 1920	0.06	14½%	—	Vomited General pains; severe after last injection Dose reduced because of signs of chronic poisoning
February 28, 1920	0.06	—	—	
March 1, 1920	0.06	—	—	
March 3, 1920	0.09	21%	No ova or blood; few pus cells	
March 7, 1920	0.09	—	—	
March 9, 1920	0.09	—	—	
March 16, 1920	—	—	—	No haematuria or pain; feels well; gaining weight
Total	1.68			

CASE II.

January 9, 1920.—There has been haematuria since July, 1916, most marked at the end of micturition. Frequency of micturition has been present at times. He complains of general weakness and loss of weight. He has also had dysentery in Egypt in 1915 and still has attacks of diarrhoea and passes blood with the motions.

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
January 21, 1920	0.03	13%	Ova and blood present	
January 23, 1920	0.06	—	—	
January 25, 1920	0.06	—	—	
January 27, 1920	0.06	13%	—	
January 29, 1920	0.06	—	—	
January 31, 1920	0.06	—	Ova and blood present	Coughing
February 4, 1920	0.09	—	—	
February 6, 1920	0.09	—	—	
February 8, 1920	0.09	—	—	
February 10, 1920	0.12	—	—	
February 12, 1920	0.12	—	—	
February 14, 1920	0.12	—	—	
February 16, 1920	0.12	22%	No ova, pus or blood	
	1.08			
February 24, 1920	0.12	—	No ova	
February 26, 1920	0.12	—	—	
February 28, 1920	0.12	—	—	
March 1, 1920	0.12	—	—	
March 5, 1920	0.12	—	—	
March 7, 1920	0.12	—	—	
March 17, 1920	—	—	—	Took injection well No haematuria; gaining weight; feels much better
Total	1.8			

7-10 days, but in all but one there was subsequently a marked increase, varying from 2½ to 28, the highest percentage being 41. The average increase was 12%. Urinary examinations usually revealed that coincident with the increase in eosinophile cells the ova were absent or, if present, they were degenerated. From this point of maximum eosinophilia the tendency was for the percentage to decrease rapidly.

Unfortunately, we were unable to make accurate daily observations and the blood was only examined once a week. The blood films were, moreover, occasionally damaged or lost in transit from the hospital to the Adelaide Pathological Laboratory. Consequently the records of blood examination are not as full and complete as they should be, but the graph charted from the available figures is very striking.

CASE III.

February 9, 1920.—The patient contracted bilharziosis in Egypt in 1917. The symptoms commenced suddenly with frequency and pain on micturition, haematuria and loss of weight. At the present time he is passing more blood than he had before admission. He also has attacks of pain in right side and nausea. The patient is a pale looking man. He complains of tenderness over the right iliac fossa. No ova are seen in the faeces. The urine contains ova, pus and blood.

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
February 10, 1920	0.03	—	Ova and pus present	
February 12, 1920	0.03	—		
February 14, 1920	0.06	—		
February 16, 1920	0.06	11%		
February 20, 1920	0.09	—		
February 22, 1920	0.09	9%		
February 24, 1920	0.09	—		
February 26, 1920	0.12	—		Paroxysmal coughing
February 28, 1920	0.12	—		
March 1, 1920	0.12	—		
March 3, 1920	0.12	11%	No ova; a few pus and blood cells	Complains of pains and stiffness of neck and shoulder
March 5, 1920	0.93	—		
March 7, 1920	0.12	—		
March 9, 1920	0.12	—		
March 11, 1920	0.12	—		
March 16, 1920	0.12	13½%	No ova; few pus cells	
March 18, 1920	0.09	—		
March 24, 1920	0.09	—		
March 26, 1920	0.09	—		
June 1, 1920	—	—	No ova, pus or blood	Micturition normal; no haematuria; no pain or tenderness
August 3, 1920	—	—		No return of haematuria or urinary symptoms; still has slight pain in back
Total	1.80	—		

CASE IV.

March 3, 1920.—The patient had washed his feet and had drunk water from Canal Telekébir. The first indication of infection was the passing of blood in the urine about two months after, in October, 1916. He became easily tired and depressed with severe headaches. He lost weight. There was frequency and painful micturition, especially at the end of the act. He had passed blood per rectum and had become more or less constipated. No specific treatment was instituted until March 3, 1920. His face was pale and lined. The urine contained ova and pus. The other systems appeared to be normal.

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
March 3, 1920	0.03	—	Ova and pus present	
March 5, 1920	0.06	—		
March 7, 1920	0.09	—		
March 9, 1920	0.12	—		
March 11, 1920	0.12	—		
March 16, 1920	0.12	16½%		
March 18, 1920	0.12	—		Severe vomiting
March 21, 1920	0.06	—		
March 23, 1920	0.06	—	No ova; few blood and pus cells	
March 26, 1920	0.78	—		
March 28, 1920	0.09	—		
March 30, 1920	0.09	—		
April 7, 1920	0.09	32%		
April 9, 1920	0.09	—	No ova or pus; occasional blood cell	
April 12, 1920	0.09	—		
April 14, 1920	0.09	—		
April 16, 1920	0.09	24%	No ova, pus or blood	Aching pains in both shoulders
April 19, 1920	0.09	—		
April 21, 1920	0.09	—		
April 23, 1920	0.09	—		
April 28, 1920	—	—	One dead ova; no pus or blood	
May 29, 1920	—	9%	Two or three degenerated ova; no pus or blood	Feels much better; depression and tired feeling disappeared; frequency and haematuria cleared up; eating better and has put on weight; still has headaches and bowels tend to be constive; general appearance greatly improved
July 7, 1920	—	—	No ova, pus or blood cell discovered	
Total	1.77	—		

CASE V..

The patient contracted the infection in Egypt in 1916 through drinking and swimming in Sweet Water Canal. In October he noticed haematuria, but felt quite well. Since then he has had occasional frequency, more marked in hot weather and burning towards end of micturition. He noticed blood in the motion two years ago, but has piles. Three months ago a rash appeared on his face. This has disappeared. He is a healthy, well-nourished man. His tongue is clean. His heart, lungs and abdominal organs appear to be healthy.

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
January 21, 1920	0.03	5%	Ova, pus and blood present	
January 23, 1920	0.06	—	Ova present	Vomited
January 25, 1920	0.03	—	Ova present	
January 27, 1920	0.06	3%		Nausea; sore arm following escape of fluid into tissue
February 20, 1920	0.03	5%	—	
February 22, 1920	0.06	—	—	
February 24, 1920	0.06	—	No ova	
		0.33		
February 26, 1920	0.09	—	—	
February 28, 1920	0.09	—	—	
March 1, 1920	—	5%	A few ova, pus and blood	
March 3, 1920	0.09	—	—	
March 5, 1920	0.12	—	—	
March 7, 1920	0.12	—	—	
March 9, 1920	0.12	—	—	
March 10, 1920	0.09	4½%	No ova, pus or blood	Shoulder and side of neck stiff and aching
March 18, 1920	0.09	—	—	
March 21, 1920	0.09	—	—	
March 26, 1920	0.09	—	—	
March 28, 1920	0.09	—	—	
March 30, 1920	0.09	—	—	
April 1, 1920	—	—	Ova present	
April 29, 1920	—	—	No ova, pus or blood	
June 2, 1920	—	—	No ova, pus or blood	
July 6, 1920	—	—	No ova, pus or blood cells detected	
Total	1.5			

CASE VI..

February 9, 1920.—This patient contracted bilharziosis in Egypt in 1917, when he commenced to pass blood in his stools. Haematuria commenced 12 months later. He now passes blood with his stools and on micturition. There is frequency and pain on micturition. He is easily tired on exertion, but otherwise feels well. He is an anemic looking man. The faeces do not contain ova. In the urine are ova, pus and blood. The other systems are normal.

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
February 10, 1920	0.03	—	Urine—ova and pus present; faeces—no ova	
February 12, 1920	0.03	—	—	
February 14, 1920	0.06	—	—	
February 16, 1920	0.06	13½%	Ova present	
February 20, 1920	0.09	—	—	Vomited
February 22, 1920	0.09	15%	No ova or blood	
	0.36	—		
February 24, 1920	0.09	—	—	Vomited
February 26, 1920	0.09	—	—	
February 28, 1920	0.12	—	—	
March 1, 1920	0.12	38½%	One degenerated ovum; blood and pus cells	Vomited
March 3, 1920	0.12	—	—	
March 5, 1920	0.12	—	—	
March 7, 1920	0.12	—	—	
March 9, 1920	0.06	—	—	
March 10, 1920	—	—	—	
	0.36	—		
March 15, 1920	—	—	—	
March 16, 1920	—	—	—	
April 29, 1920	—	—	No ova, pus or blood	Still weak, but has made an uninterrupted recovery
May 26, 1920	—	6%	Moderate number of ova and a few blood cells	Quite well; no symptoms of bilharziosis
June 15, 1920	—	3%	No ova, pus or blood	No return of symptoms; feels very well
Total	1.2			

CASE VII.

April 9, 1920.—The patient bathed in Canal Tel el kebir in 1916. He complained of pains in the back, but did not notice haematuria until his return to South Australia in March, 1920. He passes blood with motions, especially after exertion. He has had pains in the back continuously. No specific treatment was applied until April 9, 1920. There are no physical signs. Many terminal spined ova and scattered blood cells are present in the urine. The eosinophile cells constitute 5% of the leucocytes. His weight is 63.3 kilograms.

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
April 9, 1920	0.03	5%	Numerous ova; few blood cells	
April 12, 1920	0.06	—	—	
April 14, 1920	0.06	—	—	Violent paroxysmal cough; difficulty in getting breath
April 16, 1920	0.06	—	Many ova; no pus or blood	
April 19, 1920	0.06	2%	—	Pains between shoulders
April 21, 1920	0.06	—	—	—
April 23, 1920	0.06	—	—	—
April 25, 1920	0.06	—	—	Sever paroxysmal cough
April 28, 1920	0.09	—	One ova (dead); no pus or blood	
April 30, 1920	0.54	—	—	
May 3, 1920	0.06	—	—	
May 5, 1920	0.09	—	No ova; few pus cells	Cough not so severe
May 7, 1920	0.06	—	—	—
May 10, 1920	0.06	7%	—	Severe coughing
May 12, 1920	0.06	—	No ova, pus or blood	Coughing
May 14, 1920	0.09	5%	—	—
May 17, 1920	0.09	—	No ova or blood; few pus cells	—
May 19, 1920	0.06	—	—	—
May 21, 1920	0.09	—	—	Cough
May 24, 1920	0.09	—	No ova, pus or blood	Cough
May 26, 1920	0.09	—	—	Cough
May 28, 1920	0.09	—	—	Cough
May 31, 1920	0.09	—	—	Severe cough; difficulty in getting breath
June 2, 1920	—	—	—	—
June 10, 1920	—	4.3%	No ova, pus or blood	—
June 16, 1920	—	2.5%	No ova, pus or blood; faeces—no ova, few red cells	Feels very well
Total	1.62			

CASE VIII.

The patient bathed in various canals in Egypt in 1915. He first noticed an urticarial eruption on the trunk in August, 1916, accompanied by slight fever and malaise. He was quite well from then until May, 1917, when he noticed haematuria and began to lose weight. Pains in the back and general weakness also occurred. He passed blood with the motions. The stools were examined at No. 14 Australian General Hospital and bilharzia ova were found. No specific treatment was given until August, 1919, at No. 7 Australian General Hospital, when a course of seven injections of tartar emetic was given, one dose every other day. The urine cleared up and remained clear for three months, when he was re-admitted.

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
April 7, 1920	0.03	2%	Bilharzia ova present	
April 9, 1920	0.06	—	—	Vomited
April 12, 1920	0.06	—	—	—
April 14, 1920	0.06	—	—	
April 16, 1920	0.09	—	Few ova; no pus or blood	
April 19, 1920	0.09	2%	—	Vomited
April 21, 1920	0.09	—	—	Coughing
April 23, 1920	0.09	—	—	—
April 25, 1920	0.09	—	—	—
April 28, 1920	0.09	—	No ova or blood; few pus cells	—
April 30, 1920	0.09	—	—	
May 3, 1920	0.09	—	—	
May 5, 1920	0.12	9%	No ova; few pus cells	
May 7, 1920	0.12	—	—	
May 10, 1920	0.09	—	—	
May 12, 1920	0.12	5%	No ova, pus or blood	
May 14, 1920	0.12	—	—	
May 17, 1920	0.12	—	—	
May 19, 1920	0.06	18%	No ova or blood; few pus cells	
May 21, 1920	0.06	—	—	
May 24, 1920	0.12	—	No ova, pus or blood	
May 26, 1920	0.15	4.5%	—	Vomited badly
May 28, 1920	0.12	—	—	Cough
May 31, 1920	0.09	—	—	Slight cough
June 2, 1920	—	15.5%	No ova, pus or blood	
June 9, 1920	—	23%	No ova or blood; few scattered pus cells	
June 16, 1920	—	5%	No ova; occasional pus cells	Pains in back disappeared; feels much better
Total	2.22			

CASE IX..

The patient bathed in canals at Quara between March and April, 1916. He first noticed haematuria and pain in the back in May, 1917. Since infection he has lost weight. His weight before infection was 80.75 kilograms. No blood has been noticed in the motions. No specific treatment was instituted until April 21, 1920.

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
April 21, 1920	0.03	—	Many ova and a few pus cells	
April 23, 1920	0.03	—	—	
April 25, 1920	0.03	—	—	
April 28, 1920	0.06	—	—	
April 30, 1920	0.06	—	No ova or blood; few pus cells	
	0.21	—	—	
May 3, 1920	0.06	—	—	
May 5, 1920	0.09	4%	Several ova; few pus cells	
May 7, 1920	0.09	—	—	
May 10, 1920	0.09	—	—	
May 12, 1920	0.09	14%	No ova, pus or blood	
May 14, 1920	0.12	—	—	
May 17, 1920	0.12	—	—	
May 19, 1920	0.06	—	No ova or blood; few pus cells	
May 21, 1920	0.09	—	—	
May 24, 1920	0.12	—	—	
May 26, 1920	0.12	9%	No ova, pus or blood	
May 28, 1920	0.15	—	—	Paroxysmal cough; up to this had taken course very well
May 31, 1920	0.12	—	—	
June 2, 1920	—	11%	No ova or blood; very few scattered pus cells	
June 9, 1920	—	2.5%	No ova or blood; few scattered pus cells	
June 16, 1920	—	2.3%	No ova; few pus cells	No pains in back; feels much better
Total	1.53			

CASE X..

Date.	Dose. (Gramme.)	Eosino- philia.	Urine.	Remarks.
May 19, 1920	—	8%	Ova, pus and blood	
May 24, 1920	0.03	—	—	
May 26, 1920	0.06	8%	Many ova and blood cells	
May 28, 1920	0.09	—	—	
May 31, 1920	0.12	—	—	
June 2, 1920	0.12	15%	Active ova, pus and blood	Slight cough Lost 18 kilograms since May 26, 1920
June 4, 1920	0.12	—	—	
June 8, 1920	0.12	—	—	Slight cough
June 10, 1920	0.12	12%	Few ova (dead); few pus cells; no blood	
June 12, 1920	0.06	—	—	
June 14, 1920	0.09	—	—	
June 16, 1920	0.09	13%	No ova and pus; few red cells	
June 18, 1920	0.09	—	—	Severe pains following last injection
June 23, 1920	—	9%	No ova, pus or blood	

ANALYSIS OF RESULTS.

Case No.	Increase in Eosino- philia.	Alteration in Weight During Course. (Kilograms.)	Total Before Urine Negative. (Grammes.)	Total Amount Given. (Grammes)	Subsequent Examinations.
1	14%	—18	1.14	1.68	
2	28%	—20.25	1.08	1.80	Urine negative 2 months after completion
3	24%	—22.7	0.81	1.74	Urine negative 2 months after completion
4	15%	—13.6	0.72	1.77	Urine negative 3 months after completion
5	2%	—15.9	0.27	1.62	Urine negative 3 months after completion
6	23%	—2.25	0.45	1.20	Urine negative 3 months after completion
7	7%	—9	0.54	1.62	Urine negative 1 month after completion
8	20%	—13.6	0.72	2.19	Urine negative 3 weeks after completion
9	10%	—36	0.66	1.53	Urine negative 1 month after completion
10	7%	—15.9	0.66	1.11	Urine negative 1 month after completion

Average increase: 12.3%. Average loss of weight: 16.58 kilograms. Average dose before urine negative: 0.72 grammes.
Average given: 1.62 grammes.

Results of Treatment.
Urinary Examination.

The presence of ova, pus and blood usually in small amounts was constant in the ten cases. In all the ova disappeared entirely or, if present, were dead (*i.e.*, did not hatch in water) by the end of the course. In the majority the pus and blood cells shared a similar fate, while in the others only a few scattered cells could be found. Disappearance of ova occurred on the average by the end of the third week after 8 to 12 injections averaging 1 grammme (15.4 grains). Blood and pus cells were markedly fewer by the same time and usually absent at the end of the course.

Examinations of Faeces.

Several patients complained of passing blood with the stools, but the ova could not be found in any of the specimens, although in several blood cells were present.

Symptoms.

Once the course of the injections was finished, it was remarkable how quickly the general appearance and condition of the patients improved. In those who had complained of frequency of micturition this was much less. The feelings of malaise and tiredness was invariably relieved; the patient increased in weight. Backache disappeared and all expressed themselves as feeling improved in health.

I must thank the Registrar of No. 7 Australian General Hospital for permission to publish these cases and especially do I thank Colonel de Crespigny and Colonel Hayward for their encouragement and advice in writing this paper. Finally, I am indebted to Captain Hecker for notes on three of his cases and assistance in the treatment of others.

Reviews.

TREATMENT BY SUGGESTION.

In "Advanced Suggestion (Neuro-Induction),"¹ Dr. Haydn Brown describes a special form of psycho-therapy, together with the psychological theories upon which it is based. The author claims that by the method of neuro-induction (which is the name by which he prefers to call this particular manner of employing suggestion) the patient gets an insight into his own subconsciousness and obtains curative benefit by having his difficulties explained away with the help of the medical adviser. The meaning of every procedure is explained to the patient in the simplest words, so that mystery is impossible. The aim of the medical man is to get the patient into a state of absolute physical and mental rest by certain means, such as posturing and shutting the eyes, so as to exclude all disconcerting stimuli. In this state the patient's subconsciousness is most easily approached and inducted or treated by suggestion. It is when in a condition of greatest physical and mental relaxation that thought is most concentrated and the patient capable of the deepest thinking. Neuro-induction calls for no effort on the part of the patient. If, during the induction, the patient moved in the slightest or uttered any word, then the relaxation requisite for fullest perception would not be present. Neuro-induction denotes the education or re-education of the mental and physical systems, the patient being led from one clear understanding to another, the physician's plain and simple reasoning appealing to the inner conscience. An initial analysis is made to discover the presence of some conflict, the analysis being quite different from that of Freud and Jung. Dr. Brown differs from these psycho-analysts in

regard to the question of sexual complexes, which he considers are present in less than one-tenth of all cases. The cause of the trouble may be worry, insomnia, dyspepsia, etc., and neuro-induction explains the matter to the patient, so that normal functioning follows.

The psychology adopted by the author includes many new terms. "Panapsis" is normal health of all neurones, *i.e.*, with current communication between the neurones by means of the synapses; other compounds of "apsis" indicate different variations in functioning, *e.g.*, "psychanapsis" means loss of current communication between thought complexes, thus producing "dissociation." To remedy this dissociation or psychanapsis, neuro-induction is employed and the quiet thinking of the patient in a subconscious manner, with the aid of helpful suggestion from the medical adviser, brings about a correct way of thinking. Panapsis is thus restored by re-education. The author compares the relative values of neuro-induction and neuro-conduction (hypnosis), claiming that the former is more beneficial to the patient, as it exercises his unhindered reasoning powers to the best of his ability, whereas the latter leaves the patient more or less dependent upon the medical man's thoughts.

Chapter II. is devoted to some object lessons of cases treated by this method. In it the author claims to have cured prolapse of the rectum in a child of two and a half years of age and also lateral curvature of the spine in a patient who had suffered years of agony in plaster of Paris. Amongst other new terminology, the expression "negative circling" is used in the sense of vicious cycle. For example, worry, insomnia, dyspepsia, pain, constipation, despair, drug mania and loss of weight constitute negative or unfavourable circling, each one of the symptoms mentioned being called "arcs." Favourable or positive circling includes psycho-therapy, medicines, diet, local applications and sedatives. During treatment by neuro-induction the clearing up of one negative arc aids materially in treating the remainder. The author claims successes in the treatment of functional diseases of practically all of the systems and even in the treatment of what may be called straight-out surgical cases, including tumours and new growths.

Chapter XXI. contains a number of rules for the practice of neuro-induction, but the author points out that only practice will bring proficiency, just as the best text-books in the world will not make a person excel in golf, piano playing, or black and white drawing. Provided there is some intelligence left to work upon, neuro-induction is considered valuable in the treatment of insanity, many cases having been brought to a successful termination through its agency. In the chapter on the simplification of psychology Dr. Brown points out the error of calling the subconscious the unconscious, because the subconscious is in reality paramount to the conscious, just as the chief of a big business concern, in his secluded office is superior to the sub-managers of the various branches. When the chief, *i.e.*, the subconscious, is isolated from all other distracting influences, he can concentrate all his thought on the matter in hand.

As an exposition of a new variety of psycho-therapy, the book is of some considerable interest and its claims of successful treatment are not one whit behind those of other methods of treatment by suggestion. Comparing the hard-and-fast assertion of Jung and others, that psycho-analysis has no trace of the element of suggestion in it, with the neuro-induction of Haydn Brown, which is a mixture of auto- and altero-suggestion, we would expect to find a much greater difference in the methods of treatment than there actually is, a fact which goes far to contradict the claim that psycho-analysis is not another form of suggestion.

There is one chapter in the book, that on failures, which is rather unique; works on the subject of psycho-therapy are apt to give the impression that failures are unknown; this chapter is a frank account of the class of ailments where the author has not been successful. We can all agree with the author when he states in his closing chapter, named "The Future," that "the future of psycho-therapy is assured" and while we must confess that treatment by suggestion has not been availed of by the medical profession to the extent that it should have been, we may well pray to be delivered from cumbersome theories and methods of application of this form of treatment from which we have suffered in the past and from which this book of Dr. Brown's points a way to simpler methods. There is something of use in every page.

¹ Advanced Suggestion (Neuro-Induction), by Haydn Brown, L.R.C.P., etc.; 1918. London: Baillière, Tindall & Cox; Crown 8vo., pp. 342. Price, 6s. net.

The Medical Journal of Australia.

SATURDAY, AUGUST 27, 1921.

The Medical Congress.

The Federal Committee of the British Medical Association in Australia appointed a sub-committee in February, 1921, to formulate a draft constitution for the Australasian Medical Congress (British Medical Association), including rules and standing order for submission to the Federal Committee. This draft was not ready when the Committee met in July. It was, therefore, determined that the draft should be submitted to the Chairman and members as soon as possible and that, pending the adoption of a constitution, the Council of the Victorian Branch should be asked to nominate a President for the first congress. The position at the present time may be summarized in a few words. The first congress is to be held in Melbourne in 1923 under the auspices of the Federal Committee and of the New Zealand Branch of the British Medical Association.

The Federal Committee has given the sub-committee very little guidance in its task. Only one resolution was adopted at the meeting held in February touching on this matter. It reads as follows:

That the objects of the Congress be made to conform generally *mutatis mutandis* to those of the Annual Meeting of the British Medical Association.

The Annual Meeting of the British Medical Association is exclusively a scientific congress. Its activities are limited to the reading of papers on professional subjects at sessions of the sections or at combined or plenary sessions and to social functions. Medico-political and medico-ethical subjects have been included among the matters which may be discussed during the past few years, but the determination of policy in connexion with medico-political, medico-ethical and medico-sociological questions is excluded from the purview of the annual meeting and entrusted to the Representative Body, whose members are instructed on these matters by majority vote in the constituencies. It may consequently be stated that the annual meetings of the British Medical Associa-

tion are established for the distribution of scientific knowledge and for the exchange of opinions on medical problems. If the new congress adopts this principle for its constitution, it will differ essentially from the old congresses, in that no resolutions will be passed in the sections and confirmed by congress in general session.

The machinery for the conduct of the congress has yet to be constructed. In the United Kingdom the Council of the Association has been primarily responsible for the meetings. The election of the President has remained in the hands of the Council. The selection of the readers of addresses and the arrangements of the sections has rested with the Council, who have been advised upon some matters by the Arrangements Committee and upon others by the Science Committee. The Business Manager and Financial Secretary has had complete control of the arrangements for the exhibition of foods, drugs, instruments, etc. The expenses in connexion with the meetings of the sections and with entertainments have been defrayed by a local committee, except in regard to the printing of the daily journal and to some of the expenses of the sections. The profits from the exhibition have been handed over to the local committee for the purpose of lessening the burden of the meeting. Various committees and sub-committees have been established locally, including those dealing with entertainments, with the reception arrangements, with excursions, with the medical museum, with the accommodation of visitors, with the publication of a guide book and with the financial arrangements. At each annual meeting there has been an annual dinner, for which members have been required to pay a reasonable sum. No subscription has been charged for members attending the annual meeting.

The Federal Committee will, no doubt, endeavour to save as much of the procedure that obtained in connexion with the Australasian Medical Congress as is consistent with a meeting of the British Medical Association in Australasia. Certain changes are inevitable and many are desirable. It is to be hoped that means will be devised to render the expense to the members of the Branch in the area of which the congress will be held, less of a burden than it has been in the past. The question of a subscription to the meeting will have to be determined by the Fed-

eral Committee. The publication of the proceedings of the congress will also have to be considered in the light of the altered circumstances. In the United Kingdom the papers read at the annual meetings are the property of the British Medical Association and cannot be published elsewhere than in the *British Medical Journal*, except by special permission. *The Medical Journal of Australia* at present is not large enough to permit of the publication of all the papers read at a congress, but it is possible that the Federal Committee may arrange with the Australasian Medical Publishing Company, Limited, for the publication of either a special series of supplements of this *Journal* or of a separate volume of proceedings. There is evidence that the Federal Committee is determined to improve the congress and to make it even a more valuable instrument for the furtherance of medical knowledge than it has been in the past.

THE SECRET OF ANÆSTHETIC ETHER.

If the statement had been made some years ago that ether in a pure state was not an anæsthetic, the remark would have fallen on incredulous ears. Last year, however, Dr. J. E. Lombard, of New York, showed that when ethyl ether was prepared free of impurities, its anæsthetic action was negligible. This discovery, together with the work of Dr. J. Cotton, of McGill University, on the impurities of anæsthetic ether, has prepared the way for a further contribution to the subject by Drs. R. L. Mackenzie Wallis and C. Langton Hewer.¹ Dr. Mackenzie Wallis has prepared pure ether from ethyl alcohol and pure sulphuric acid, followed by fractional distillation. With this substance he has failed, like Dr. Lombard, to produce anæsthesia in animals, even when enormous doses were administered. The action was more intoxicant than anæsthetic. It was obvious that the anæsthetic effects of so-called ether must be due to one or more of its contained impurities. The pre-formed impurities of most ethers are alcohol, water, acetone, mercaptans and thio-ethers. Impurities formed by oxidation include aldehydes, peroxides and acids. The mercaptans are evil-smelling substances of extremely poisonous nature. Dr. Wallis found that these were the chief impurities in ether which had caused temporary failure of respiration in two patients shortly after commencement of administration. He investigated other samples of ether, which were free from aldehydes, mercaptans and allied noxious bodies. These were found to have good anæsthetic properties. He treated them with finely divided potassium permanganate to produce oxidation of the contained impurities and found that the residue was pleasant to the sense of smell. The residue was found to contain ketones. Assuming that the anæsthetic properties

of ether were due to the presence of ketones and that these latter were the requisites for good and safe anæsthesia, Dr. Wallis used pure ether as a volatile solvent for these bodies and the result was an excellent anæsthetic substance. Further, he took advantage of Dr. Cotton's discovery that good anæsthesia could be obtained by the solution of carbon dioxide and ethylene in ether. He treated the mixed ketones with carbon dioxide and ethylene and then added them to the ether. The new anæsthesia thus produced has been used on 500 patients with considerable success. It was found necessary to put its manufacture in the hands of wholesale chemists, and it has been placed on the market under the name "ethanesal."

By supplementing and extending the discovery of Lombard, Dr. Mackenzie Wallis has performed a very signal service. It is far more important to establish the fact that the anæsthetic properties of ether are dependent on higher, unidentified ketones and that pure ether which possesses little or no narcotic action, can be changed into a powerful anæsthetic by the addition of these impurities, than to introduce a new anæsthetic, however reliable. New drugs should be accepted with caution. In the capable hands of Dr. Hewer anæsthesia induced by ethanesal may be pleasant and free from risk. This new anæsthetic, however, has yet to run the gauntlet of extensive trial by other anæsthetists.

Dr. Mackenzie Wallis's work contains a promise of a further practical advance in connexion with anæsthetics. It may be possible to free anæsthetic ether of extraneous substances, such as mercaptans. Similar researches may disclose analogous poisonous substances in chloroform used for anæsthesia. At the same time, this work necessitates a revision of the bio-physical doctrines connected with this subject. It will be remembered that some years ago Hans Meyer demonstrated that any physical or chemical means which temporarily disturb the physical condition of the lipoids contained in the envelope of the cerebral cells, gave rise to narcosis. He showed that when a frog whose cerebral lipoids had a lower melting point than those of the mammals, was immersed in water at 37° C., it fell asleep. The narcosis was interrupted when the body was cooled by immersion in cold water. He showed further that ether and chloroform acted as temporary solvents of the lipoid substances and that when the lipoids were in a condition of partial solution, the metabolism of the cell was blocked. It would seem that the fat-solvent properties of ether are inherent to the pure substance and are not dependent on the admixture of ketones with ether. If this be correct, Hans Meyers's theory, in so far as it affects ether anæsthesia, must be discarded.

THE DIGGERS' LOAN.

This is not a political newspaper and consequently a discussion of the financial policy of the Federal Government would be out of place in these columns. Every individual medical practitioner has his own views concerning the wisdom or unwisdom of the general expenditure by those elected to carry out the government of the Commonwealth. *The Medical Journal of Australia* has no concern with the individual

opinions of members on extra-professional topics. There is, however, an exception to this general rule. This *Journal*, like every other institution in this wonderful continent, associates itself with the authorities in the determination that the Digger of the Great War shall receive his due. Unfortunately, there is no legal or other control over employers and the citizens generally which could guarantee for every returned man a good "job" and a generous remuneration for civil work. There is no practical scheme for recompensing in proportion to the magnitude of the sacrifice, all those who risked everything. The Government, through its Repatriation Department, has obligations to fulfil to the Digger. In this business, the man in the street has no right to concern himself with the general question of the underlying policy. There is one question, and one only, which each one of us should ask ourselves. It is: "What is my share?"

The Government must have £10,000,000 for the Diggers. This sum is being borrowed from the people on generous terms. For £96 you can buy a £100 bond bearing 6% interest. You need not pay the capital amount at once. On the instalment plan, you may deposit £10 on or before September 5, 1921; £20 will be payable on October 3, November 7 and December 5, 1921, and the balance of £26 to complete the £96 will fall due on January 9, 1922. The interest will not be taxable by the State Governments. Moreover, for each £100 bond purchased, bonds or stock for an equal amount in any previous war or peace loan can be converted at par, provided that an application is made not later than September 5, 1921. The Diggers' Loan is a safe and good investment. Don't forget that you should apply for your share not later than September 5, 1921.

Naval and Military.

APPOINTMENTS.

The following appointments, promotions, etc., have been announced in the *Commonwealth of Australia Gazette*, Nos. 59 and 62, of July 21 and August 4, 1921.

Australian Imperial Force.

APPOINTMENTS TERMINATED.

First Military District.

Major A. J. MacDonald, 18th November, 1920.

Third Military District.

Lieutenant-Colonel H. J. Williams, D.S.O., 11th April, 1919.

Major H. H. D. Turnbull, 23rd September, 1918.

Major R. St. C. Steuart, 2nd May, 1919.

Major S. M. Ware, 17th July, 1919.

Captain J. F. Patrick, 6th August, 1919.

Captain W. J. Trewella, 6th September, 1919.

Fourth Military District.

Major I. B. Jose, M.C., 10th December, 1918.

Australian Military Forces.

Second Military District.

Reserve of Officers—

Captain R. C. Bassett is appointed to the Australian Army Medical Corps, 5th Military District, 1st July, 1912.

The temporary rank of Major granted to Honorary Captain W. B. Dight is terminated, 30th June, 1921.

Third Military District.

Australian Army Medical Corps—

Captain S. H. Allen is transferred to the Reserve of Officers, 1st July, 1912.

Colonel A. H. Sturdee, C.M.G., V.D., to relinquish the temporary appointment of Principal Medical Officer, 3rd Military District, and to be transferred to the Unattached List, 30th June, 1921.

Lieutenant (Honorary Captain) V. G. Webb is transferred to the Reserve of Officers and to be Captain, 1st May, 1921.

Reserve of Officers—

Honorary Captain K. G. McK. Aberdeen is transferred to the Reserve of Officers, 5th Military District, and to be Captain, 1st June, 1921.

The temporary rank of Lieutenant-Colonel granted to Honorary Major J. T. Mitchell is terminated, 24th April, 1920.

Australian Army Medical Corps Reserve—

To be Honorary Captain—

Walter Henry Steel, 31st December, 1918.

Fifth Military District.

Australian Army Medical Corps—

Major J. Bentley, M.C., is appointed from the Reserve of Officers, and to be Captain, 1st July, 1921.

Captain T. R. Jagger, M.C., is appointed from the Reserve of Officers, 1st July, 1921.

Captain R. C. Bassett is appointed from the Reserve of Officers, 2nd Military District, 1st July, 1921.

Captains A. Juett and H. B. Gill are appointed from the Reserve of Officers, 1st July, 1921.

Captain A. E. Cullen is transferred to the Reserve of Officers, and to be Major, 1st July, 1921.

Captain A. E. Morton is transferred to the Reserve of Officers, 1st July, 1921.

Captain (provisionally) D. R. C. Tregonning is transferred to the Reserve of Officers, and to be Honorary Captain, 1st July, 1921.

Lieutenant (provisional) B. C. Cohen is transferred to the Reserve of Officers and to be Honorary Captain, 1st July, 1921.

Reserve of Officers—

Honorary Captain K. G. McK. Aberdeen is transferred from the Reserve of Officers, 3rd Military District, and to be Captain, 1st June, 1921.

Honorary Captain A. E. D. Clark is transferred from the Reserve of Officers, 2nd Military District, and to be Captain, 1st June, 1921.

Sixth Military District.

Australian Army Medical Corps—

The resignation of Captain C. F. Hodgkinson of his provisional and temporary appointment is accepted, 30th June, 1921.

We regret to announce the death of Dr. George Pender-Smith, which took place at Chinchilla, Queensland, on August 4, 1921. Dr. Pender-Smith, who was 61 years of age, was qualified in London in 1892. He practised for 20 years in Essex. He held the position of Medical Officer of Health at Wivenhoe for 18 years. In 1911 he came to Tasmania and practised for three years on the west coast. For a time he was engaged at the Hospital for the Insane at New Norfolk. Later he went to Queensland and settled in Sandy Gallop. More recently he re-entered private practice at Chinchilla.

In the speech of His Excellency the Governor at the opening of the Queensland Parliament, reference was made to the proposal to alter the existing health legislation in regard to sewerage and drainage, the treatment of venereal disease, the regulation and inspection of food and drugs, the registration of nurses and the protection against lead poisoning. His Excellency also pointed out that the existing provisions of the *Infant Life Protection Act* relating to the adoption of children have not been satisfactory and that a Bill would be introduced to amend the Act.

Abstracts from Current Medical Literature.

OPHTHALMOLOGY.

(88) Palsies of Conjugate Ocular Movements.

According to Gordon Holmes, conjugate movements of the eyes result from voluntary impulses and may occur as reflex movements from various peripheral stimuli (*Brit. Journ. of Ophthalm.*, June, 1921). These conjugate movements are governed by centres, cortical and subcortical. The best-known cortical centre is the second frontal gyrus. An irritant lesion of this region excites clonic conjugate movements to the opposite side; destruction of the region, as by gun shot wounds, produces weakness and slowness of conjugate movements to the opposite side. The angular gyrus has been described as a second cortical centre, but the author considers the special disturbance of ocular movements in lesions of this region to be more of the nature of apraxia—that is, failure to obey an order to look in any direction. A third centre has been claimed for the visual area of the occipital lobe, but the movements of the eyes elicited from it are more truly reflexes from the production of visual perceptions, just as in hemianopia there is a transient deviation of the eyes away from the hemianopic side. Diseases of the brain stem produce the most complete and permanent disturbance of the conjugate movements of the eye. A lesion in the region of the left abducens nucleus may make the patient unable to move either eye to the left of the middle line, showing that the right internal rectus is also affected. It is necessary to assume that the nuclei are connected by association fibres, such as those of the dorsal longitudinal bundle. But the hypothesis that assumes the existence of a supra-nuclear centre near the sixth nucleus is probably more correct. Into it come all the impulses which can excite conjugate movements of the eyes to the same side, both voluntary and reflex. Destruction of it abolishes all lateral conjugate movements. Convergence movement of the internal rectus muscle may still persist. Conjugate vertical movements also possess a supra-nuclear mechanism which is probably situated in the anterior quadrigeminal bodies.

(89) Cataract in Tinplate Millmen.

In an examination of men employed in a tinplate mill, J. J. Healy found lenticular opacities in 40% of those 35 years of age and over. They were chiefly of the posterior cortical and striated cortical varieties (*Brit. Journ. of Ophthalm.*, May, 1921). Further investigation in twelve works was carried out and 424 were examined. Of 70 under 35 years only one had cataract. Of 354 men over 35 years, 144 were affected. It would appear that it takes 15 years' work in the mill to cause cataract. The author has observed 96 cases in the last thirteen months in his own

practice. The typical wedge-shaped, striated, cortical opacity below, with apex directed upwards and growing into the posterior cortex, was found in half the cases. Dense, round, posterior, cortical opacity, bottlemakers' cataract, occurred in 26 cases. A few other varieties were present. From such evidence as we have of normal incidences, it is apparent that the incidence among tinplate millmen is abnormally high. The author attributes the pathological changes to excessive exposure to infra-red rays, as the workmen are exposed practically to no ultra-violet rays. It is possible that constant absorption of infra-red rays stimulates the metabolism of the lens fibres at first. Exhaustion of metabolism follows. Possibly also there is enormous absorption of heat rays by the aqueous iris and ciliary body. The condition should probably be scheduled under the Workmen's Compensation Act. The only possible preventive measure is the wearing of suitably prepared, triplex, standardized goggles.

(90) Physiology of the Schlemm Canal.

M. Uribe-Froncoso recalls the old controversy between Schwalbe and Leber as to whether the Schlemm canal is a lymph space or a venous sinus. Leber, who maintained that it was a vein, appeared to win the day, but recent research has proved that the structure is a lymph canal and seldom contains blood corpuscles (*Amer. Journ. of Ophthalm.*, May, 1921). The author by experiments on rabbits has demonstrated its lymphatic function. More recently successful attempts have been made actually to see the region in the living human eye. Trautts by direct and indirect ophthalmoscopy in a lateral position examined the angle of the anterior chamber in eyes with a deep chamber, such as occur in association with keratoglobus and high myopia. An advance was made in 1914 by Salzmann, who used a contact glass and was able to give an accurate description of the irido-corneal angle in normal and pathological cases. Koeppe has perfected the technique and made possible the observation of the irido-corneal angle with high magnification. He used the focal illumination of the Nernst-Gullstrand slit lamp and observed the region with a Zeiss binocular apparatus, giving a magnification of 40 diameters and a stereoscopic image. He describes the canal as a clean zone, slightly darker than the inner border of the sclera, filled with a clear liquid. Even in glaucoma it was not found to be red in colour.

(91) On Fixation.

Harold Gifford gives a few hints on fixation of the eye-ball during operations upon the globe (*Amer. Journ. of Ophthalm.*, May, 1921). No one fixation is the best for the puncture and counter-puncture and upward cut in cataract extraction, but the author has decided that fixation of the internal rectus tendon is the most serviceable. If the globe is thoroughly cocainized with a 10% solution applied four or five

times in the course of half an hour, the necessity of holding the eye-ball down will seldom be felt. For an incision with the keratome in glaucoma, fixation of the superior rectus tendon is the most favourable. Under a general anaesthetic fixation of both superior and internal rectus tendons is the best plan especially in sunken eyes. Fixation by a strong thread can often be used with advantage—for instance, in enucleation and in the wall of a cyst before it is punctured. Perlmutter uses a double forceps, which fixes above and below.

(92) Traumatic Superior Oblique Paralysis.

E. A. Shumway relates a case of traumatic paralysis of the left superior oblique muscle in a man of 38 years, who had sustained a fractured skull (*Pennsylvania Medical Journal*, June, 1921). Ten months after injury he had 23° of left hypophoria and 3° of exophoria. For the relief of these cases there are four possible procedures, viz., advancement of the paretic muscle, tenotomy of its antagonist, tenotomy of its associate in the other eye and advancement of the antagonist of this associate. In the present case the author adopted the third method—tenotomy of the associate of the other eye, which in this patient was the right inferior rectus muscle. This would establish equilibrium by making the lowering of the healthy eye more difficult and elevation easier. The result was good, with a low degree of hyperphoria. Probably advancement of the inferior rectus of the same eye would be a safer procedure.

(93) Intraocular Foreign Bodies.

G. S. Derby emphasizes certain points in the treatment of foreign bodies in the eye-ball. These points are the result of his civil, as well as military, experience (*Amer. Journ. of Ophthalm.*, May, 1921). His first point is that in every injury of the eye the possibility of the presence of a foreign body should be considered. The second is that the extraction of the body should be performed as soon as possible. It is advisable not to wait for an X-ray report, but to apply the magnet at once. He considers that the one indispensable test for the presence of a foreign body in the eye is the magnet. An X-ray plate sometimes fails to reveal a foreign body which is undoubtedly present. After careful consideration he favours the anterior route, except in cases of large particles, where the lens is uninjured. When this fails he admits the value of careful localization by X-rays.

LARYNGOLOGY AND OTOTOLOGY.

(94) Ethmoidal Suppuration.

"Find the pus and follow it to its source" is Ross Hall Skillern's injunction in regard to the treatment of chronic ethmoiditis (*Journ. of Laryng. and Otol.*, March, 1921). Slow, careful and systematic examination of

every part of the nose with every means at the surgeon's disposal is required. After conservative means have been attempted middle turbinectomy should be done, a satisfactory stereoscopic skiagram taken and another systematic examination made. The sphenoid and antrum should be examined and, if necessary, treated. The posterior ethmoid cells are more likely to be affected than the anterior. If the latter are affected the circinate process should be removed to uncover the anterior cells and to facilitate removal of the lamella of the middle turbinate which usually requires resection. The remainder of the posterior cells will then be easily available. Daily irrigations of sodium hyposulphite solution are then used. If this fails, an external operation is indicated.

(95) **Closure of Antro-Buccal Alveolar Fistula.**

The successful procedure in extirpating a fistula of ten years' duration connecting the mouth through the alveolus with the antrum, is described by C. F. Welty (*Journ. Amer. Med. Assoc.*, September 25, 1920). The mucosa and periosteum were elevated from the bone in the region of the fistula and the alveolus removed to allow free communication with the antrum. The mucosa and periosteum of the hard palate in its entire length were incised in the mid-line and the periosteum elevated over the whole half of the side of the fistula. The mucoperiosteal tissue could now be easily coapted and sutured without tension over the position of the original fistula.

(96) **Foreign Bodies in the Air and Food Passages.**

Basing his remarks on the study of 789 cases, Chevalier Jackson (*Amer. Journal of the Medical Sciences*, May, 1921) discusses the symptomatology and diagnosis of foreign bodies in the air and food passages. He states that foreign bodies in the larynx cause an initial laryngeal spasm, which is followed by more or less laryngeal wheezing, croupy cough and a variable degree of impairment of phonation. There may be pain in the laryngeal region or it may be referred to the ears. A foreign body which is both thin and flat, may be tolerated for a considerable time, but increasing dyspnoea usually demands removal. Tracheal foreign bodies are usually movable and the patient is usually conscious of the movements. The vibrations may be palpated and heard with the stethoscope. Cough is usually an immediate symptom, but it may disappear and recur. It may be so violent as to induce vomiting. Sudden shutting off of the expiratory blast and phonation during paroxysmal cough is almost pathognomonic of a movable tracheal foreign body. Dyspnoea is usually present and is due to the bulk of the foreign body and the subglottic swelling caused by the traumatism of the shiftings of the intruder. An asthma-like wheeze is usually present and is often louder and of lower pitch than the wheeze of bronchial foreign bodies. It is heard at the mouth,

not at the chest wall. Pain is not a common symptom, but may occur and be accurately localized by the patient. In the bronchi initial laryngeal spasm is almost invariably present when the foreign bodies are of organic nature. A diffuse laryngo-tracheo-bronchitis develops within 24 hours in children under two years, with fever, toxæmia, cyanosis, dyspnoea and paroxysmal cough and the child may "drown in its own secretions." Lung abscesses form rapidly. An acute obstructive emphysema is present in the early stages. The older the child, the less severe the reaction. If the foreign body has had a prolonged sojourn in the bronchus its time of inhalation may be unknown. Cough and purulent expectoration ultimately result, even after a protracted symptomless interval. Periodic attacks of fever with chills, sweats and coughing and expulsion of much purulent foul material are very characteristic. Emaciation, clubbing of fingers and toes, night sweats and haemoptysis occur and suggest the diagnosis of tuberculosis. Pain may enable the patient accurately to localize the intruder. Sudden complete blocking of one main bronchus does not cause noticeable dyspnoea, provided its fellow is functioning, but there is a rapid onset of symptoms. There are no infallible diagnostic symptoms of oesophageal foreign body. Dysphagia is the most constant complaint. Pain may be caused by the penetration of a sharp foreign body, by inflammation secondary thereto, by impaction of a large object or by spasmodic closing of the hial sphincter. The subjective sensation of a foreign body is usually present. Foreign bodies in the stomach ordinarily produce no symptoms.

(97) **Maxillary Sinus Cancer.**

At their period of onset primary malignant tumours of the maxillary sinus show no pathognomonic signs. This is the opinion of Emile Delannoy and Jean Piquet (*Gazette des Praticiens*, May 1-June 1, 1921). Progressive sub-orbital and dental pain, a diminution of antral translucency, fetid unilateral nasal discharge, polypi or polypoidal degeneration of the mucosa of the middle turbinate, effacement of the canine fossa, a medial bulging of the antro-nasal wall and granulations covering the turbinates, may occur. The benign tumours may be liquid, e.g., simple unicocular para-dental cysts, dentigerous cysts or mucoceles of the sinus. Solid benign tumours are rare. Ocular symptoms may precede all others. Prognosis is conditioned by the site of implantation, the outlook being much graver when the tumour arises from the lower than from the upper part of the superior maxilla, by the stage of evolution and by the type of tumour. The treatment of every malignant tumour, when encapsulated and operable, is excision, total or partial, of the superior maxilla. Total excision, though at times justified, is often impossible, frequently unnecessary and has a grave mortality. Surgical treatment, of which cauterization and dia-

thermy are forms, may be combined with the use of radium, the latter often conveniently by the use of Dominici's tubes. The hard γ rays of the Coolidge tube act somewhat similarly. Radium alone may be used in inoperable cases to reduce the size of the tumour and alleviate pain.

(98) **Bronchoscopy in Mediastinal Tumours.**

Tumours affecting the organs adjacent to the trachea and bronchi frequently lead to changes in the endoscopic appearance of these structures and the location and character of these changes are more or less constant for the organ diseased. Hence John D. Kernan (*New York State Journal of Medicine*, April, 1921) urges laryngologists to familiarize themselves with this method of diagnosis.

(99) **Partial Thyroidectomy.**

The avoidance of operative and post-operative haemorrhage, of shock and of interference with the recurrent laryngeal nerve, is the advantage claimed by James Harper (*Journal of Laryngology and Otology*, March, 1921) for his method of removing thyroid growths and for partial removal of the gland itself. He advises a transverse curved incision over the tumour through the deep fascia, division of the sterno-hyoid and sterno-thyroid muscles and transverse incision through the capsule of the gland along the whole length of the isthmus. The tumour and lobe also, if the tumour has reached the size of a hen's egg, is now separated from the capsule by the right forefinger and delivered. The isthmus is then cut across and the stump ligatured. The cavity is loosely packed for 24 hours. In none of Harper's cases (over 20) was an artery ligatured, nor was there any post-operative haemorrhage.

(100) **Cavernous Sinus Thrombosis.**

T. Ritchie Rodger (*Journ. of Laryng. and Otology*, April, 1921) has recorded four cases of cavernous sinus thrombosis. He demonstrated that in the first case the superior petrosal sinus had been primarily infected from the middle or inner ear without previous involvement of the sigmoid or lateral sinuses. The second case originated from a carbuncle of the nose. In the third the sigmoid sinus was first thrombosed and the process extended to the cavernous sinus, presumably by either or both petrosal sinuses. This is the more usual route. The fourth case was due to an infection following a frontal sinusitis. The results of operation are discouraging, but Rodger believes that clots may sometimes be removed from the petrosal sinuses by aspiration, from the inferior petrosal sinus by lavage of the bulb and from the superior by removing the dressing plug from the upper end of the wound in the sigmoid sinus daily and allowing the blood to flow freely for a time. Scrupulous care should be taken in cleansing the mastoid before opening the vein and especially should endeavours be made to secure asepsis of the clot in the vein.

British Medical Association News.

ANNUAL MEETING.

The annual meeting of the South Australian Branch was held on July 8, 1921, in the Lister Hall, Hindmarsh Square, Adelaide, the President, Dr. H. Simpson Newland, C.B.E., D.S.O., in the chair. The meeting had been postponed from June 30, 1921.

Report of Council.

The Honorary Secretary presented the annual report of the Council as follows:

REPORT OF THE COUNCIL FOR YEAR ENDED JUNE 30, 1921.

Membership.

There are now 280 members of the Branch. Of those who have gone off the roll during the year, Dr. J. A. G. Hamilton, an ex-President, was at one time a very active member and had always taken a keen interest in the doings of the Branch. He has left the State to reside in Western Australia.

Meetings.

Ten ordinary and three special general meetings have been held and the Council met for business on twelve occasions. The general meetings have been well attended, the average number being about 40.

Lodge Matters.

Many meetings of the Lodge Committee were held, and conferences took place between the Committee and representatives of the lodges and of the Pharmaceutical Society and with the Friendly Societies' Medical Association. A satisfactory agreement was come to with the lodges of the metropolitan area and is now in force.

In the matter of lodge dispensing, the Council first endeavoured to bring about a separate agreement between chemists and lodges, but this the lodges would not agree to and subsequent conferences with the Pharmaceutical Society failing to bring about a satisfactory arrangement as to terms, members were advised to settle the question themselves for the time being. The Council favoured an agreement under which payment would be based on a flat or percentage rate, which the Pharmaceutical Society would not agree to, as the chemists wanted payment of a dispensing fee and of the cost of the drugs. The fee suggested by the chemists was regarded by the Council as much too high.

The Committee found that the existing and suggested fees for lodge work in the country varied so greatly that it was impossible to arrange uniform rates and advised each lodge surgeon to make his own arrangements with his lodges provided that the fees were within the limits fixed by the Council. Two members were appointed to confer with two from the Central Lodge Executive in case of failure to come to a definite agreement.

Listerian Oration.

For the first time since the outbreak of war the Council arranged for the resumption of this oration, and were fortunate in securing Mr. Fred. Bird, C.B., F.R.C.S., of Melbourne, to deliver the lecture. There were about 80 members and visitors present to hear Mr. Bird. The subject was the surgery of the knee joint and it was treated in a masterly and exhaustive manner.

Federal Committee.

Drs. H. S. Newland, C.B.E., D.S.O., and W. T. Hayward, C.M.G., M.R.C.S., are our representatives on the Federal Committee and many important questions have been dealt

Income and Expenditure Account for the Year Ended December 31, 1920.

Expenditure.		Income.	
	f s. d.		f s. d.
To Sundry Expenses, viz., Printing, Postages, Stationery, etc.	42 0 9	By Subscriptions received—	
" Salary	19 10 0	Current	1708 12 0
" University Library Grant	50 0 0	Arrears	72 11 6
" Advertising	12 6 0		781 3 6
" Subscriptions to British Medical Association, London	279 6 0	.. Subscriptions due and not received	95 6 8
" Printing Lists	2 5 11	" Sale of Lodge Circulars	1 4 9
" Exchange	1 13 2	" Interest received	17 5 4
" Federal Committee Delegates' Expenses	33 5 6		
" Subscription to <i>The Medical Journal of Australia</i>	346 15 0		
" Depreciation of Plant	7 0 9		
" Balance (Excess of Income over Expenditure for the year transferred to General Fund)	100 17 2		
	£895 0 3		£895 0 3

Balance Sheet as at December 31, 1920.

Liabilities.		Assets.	
	f s. d.		f s. d.
Medical Benevolent Fund	8 3 6	Plant Account	127 0 9
Medical Defence Fund	4 11 0	Less Depreciation	7 0 9
Subscriptions paid in advance	4 5 0		120 0 0
British Medical Association, London	128 16 11	Subscriptions Due	95 6 8
<i>The Medical Journal of Australia</i>	116 5 0	National Bank (Amount at Credit)	365 5 8
General Fund		Savings Bank (Amount at Credit)	255 10 7
Amount at credit at January 1, 1920	£729 5 5	Commonwealth Bank (Amount at Credit)	166 12 10
Add surplus for present year..	100 17 2	Savings Bank (Library Fund Account)	70 9 3
	830 2 7	Cash in Hand	18 19 0
	£1,092 4 0		£1,092 4 0

Audited and found correct as per Books of Account produced.
C. W. L. MUECKE, A.S.A.S.A.,
Auditor.
June 21, 1921.

W. A. VERCQ,
Honorary Treasurer.

with, the chief being the arrangements for the conference of delegates from overseas Branches with the Council of the British Medical Association in England. Dr. R. H. Todd has been selected to represent the Branches in Australia, and has gone to England, his expenses being defrayed by the Branches, each contributing about 7s. 6d. per member.

Members of the profession presented Sir Joseph Verco with his portrait in 1920 and Sir Joseph has re-presented it to the Branch. It is now hung in the Lister Hall.

(Signed) H. S. NEWLAND,
President.

Financial Statement.

The Honorary Treasurer submitted the financial statement and balance sheet. On the motion of Dr. H. Swift, seconded by Dr. John Corbin, the statement and balance sheet were adopted.

Presidential Address.

Dr. H. S. Newland delivered his address as retiring President, and illustrated the same by lantern slides projected on the screen of the celebrities whose lives he had portrayed.

At the conclusion of the address a series of kinematographic films of scientific interest was displayed. Dr. H. S. Newland called attention to the value of the kinematograph in illustrating and teaching of scientific subjects. This method was frequently used in the Royal Society of Medicine in London for scientific purposes. He thought that it had not yet been fully developed in Australia.

Induction of President.

Dr. Newland then introduced Dr. Bronte Smeaton to the chair. Dr. Smeaton spoke a few words in terms of high appreciation of the qualities of his predecessor.

Dr. W. T. Hayward moved that a vote of thanks be accorded to Dr. Newland for the valuable services he had given the Branch during the two years of his presidency. He felt sure that the members all realized the deep debt of gratitude they owed to him for his untiring interest in the work of the Branch.

The motion was duly seconded and carried.

Dr. Newland thanked the members for their expressions of appreciation and for the assistance they had rendered to him during his term of office.

The undermentioned have been elected as members of the New South Wales Branch of the British Medical Association:

W. J. Dalton, Esq., M.B., 1921 (Univ. Sydney), Lewisham Hospital.

S. K. Dwyer, Esq., M.B., Ch.M., 1920 (Univ. Sydney), Ourimbah.

A. M. Edwards, Esq., M.B., Ch.M., 1921 (Univ. Sydney), Lewisham Hospital.

M. F. Fitzsimmons, Esq., M.B., Ch.M., 1921 (Univ. Sydney), Lewisham Hospital.

D. W. Hawke, Esq., M.B., 1921 (Univ. Sydney), Coff's Harbour.

K. K. Spence, Esq., M.B., Ch.M., 1920 (Univ. Sydney), Iredale Avenue, Cremorne.

The following have been elected members of the Queensland Branch:

F. G. Scoles, Esq., M.B., Ch.M., 1920 (Univ. Sydney), Cairns, Queensland.

A. W. B. Stark, Esq., M.B., Ch.M., 1917 (Univ. Sydney), Maleny, Queensland.

SECTION OF PÄDIATRICS.

We have been asked to announce that a meeting of members of the New South Wales Branch of the British Medical Association interested in pediatrics will be held in the B.M.A. Library, 30-34 Elizabeth Street, Sydney, on September 6, 1921, at 4.30 p.m. The object of the meeting is to consider the advisability of forming a Section of Pediatrics of the New South Wales Branch. All members are cordially invited to attend. The conveners of the meeting are Dr. W. F. Litchfield, Dr. Selwyn Harrison and Dr. Wilfred Vickers.

The formation of the section has been advocated as a means of promoting social intercourse among practitioners interested in the care of children in health and in disease.

The section would enable paediatricians to exchange views and opinions and would act as a centre for the dissemination of scientific and clinical information. It is held that the members of the section would be in a position to consider and discuss such general questions of public health as concern child life. The work and interests of physicians and surgeons who are engaged in the study of children, could be correlated with the result that concerted action could be taken to extend knowledge in this branch of medicine. Finally, it is hoped that the section may become an authority to be consulted on all matters concerning child life.

It is of importance to note that the formation of a section of a Branch of the British Medical Association has many advantages over the establishment of an independent society. It is doubtful whether an independent society can be constitutionally affiliated with a Branch of the British Medical Association. In the next place, every member of the Branch interested in the subject can attend the meetings of a section, although the usual privileges of taking part in debates, reading papers, holding office and the like are reserved for those who join the section. The section thus serves as an educational centre for the general practitioner and for practitioners engaged in other special branches of practice. In the last place, the records of a section, if offered for publication to this *Journal*, will take precedence over the records of independent societies.

Medical Societies.

MEETING AT THE HOSPITAL FOR SICK CHILDREN, BRISBANE.

A clinical meeting was held at the Hospital for Sick Children, Brisbane, on March 24, 1921, Dr. J. Lockhart Gibson in the chair.

Dr. D. A. Cameron showed a child of six months with intussusception. The child had been attending the Out-Patient Department since March 11, 1921, on account of a chronic otorrhoea. On the evening of March 14 it had vomited. It was seen on the following morning. It had vomited and cried at 8 a.m. The breast had been taken twice between the two attacks of vomiting without any disturbance. The bowels had opened twice during the night. The stools were offensive, but there was no blood. The baby was having breast milk and lactogen. The latter was stopped and breast milk and boiled water only were given. At 1.30 p.m. on March 15, 1921, there was an evacuation of the bowels containing a trace of blood. After a dose of castor oil at 6 p.m. the bowels were again opened and a large amount of blood was passed. The child was admitted to the wards. A large intussusception was found presenting at the anus. The mother had been told to bring the child back if further vomiting occurred, but it was only the profuse passage of blood which caused her to return, as otherwise the child seemed quite normal. Dr. Cameron held that it was imperative to warn parents to bring their children to the hospital at once in every doubtful case, if vomiting recurred.

The chart in this case was of interest on account of an unusual complication, acute gastro-enteritis supervening on the fourth day. The operation had been comparatively simple. The intussusception, though apparently of about 12 hours' duration, had been reduced easily and the child stood it well. In his opinion unless the child's condition were very good, it was quite unjustifiable to adopt any method of anchoring to prevent relapse. This took time and time was the essence of the operation. Resection done in the later stages was fatal in nearly every case. Diagnosis was the essential point. It was often very difficult. Vomiting in infants was always to be regarded with suspicion, even if the stools were diarrhoeic. The main points in diagnosis were (i.) the children were nearly always strong and healthy and usually breast fed, (ii.) the onset was sudden with vomiting and crying, often at night. Frequently after vomiting there would be one or two normal stools. (iii.) On examination the most marked feature was the empty space on the right side rather than an actual tumour. The tumour tended to be present only during a spasm. In his experience both a palpable tumour in the rectum and a typical stool were rare.

The sooner the operation was done, the better. He had seen reduction carried out with ease, even after 72 hours. Treatment had formerly been directed towards reduction by pressure; this had to a large extent been given up. In view of the fact that many cases diagnosed as intussusception proved at the operation to be of a different nature, it was probable that many of the cases successfully treated by pressure were not intussusception at all. He held that the dangers were danger of rupture, a very real one in advanced cases, the very grave shock, rendering subsequent operation, if necessary, almost hopeless and the impossibility of determining when reduction was complete.

As an instance of hydrostatic pressure being entirely inapplicable, he quoted a case of volvulus in a baby five days old, with all the classical symptoms of intussusception. At operation a thrice twisted volvulus was found and unwound with perfect success. Nothing but disaster would have followed any attempt at hydrostatic pressure.

Dr. A. G. Anderson asked what part of the bowel caused the greatest difficulty in reduction.

Dr. Cameron considered that the difficult point was the small portion of caecum just beyond the appendix. He held that by far the best method of reduction was to deliver the whole bowel. It saved time; occasionally it was difficult to replace the intestines. In one case he had to open the intestine to release the gas pressure. In irreducible cases the outlook was bad. In the last 10 years at the hospital he had 56 cases with 18 deaths, i.e., 32%. The majority of the patients on whom resection had been carried out, died. As regards after treatment, he put the baby to the breast at once. He had had only two cases of failure of the abdominal wound holding, although he never used anything but through-and-through silkworm gut.

Dr. A. T. Nisbet pointed out that a most characteristic picture was seen in skylagrams of intussusceptions—a large, clear bubble of gas above and the sausage-shaped tumour below. The gas bubble was a very early effect, so that the method of diagnosis would be of value in doubtful early cases.

Dr. J. A. Cameron contrasted the figures in private and in hospital practice. In 25 years of practice, apart from cases seen in consultation, he had only seen 12 cases. He laid great stress on the facial expression of the patients—the babies looked ill and distressed. He had operated on the twelve patients. All had recovered except one, in whom the intervention was attempted too late. He had been unable to determine whether it was the duration of the condition that had proved fatal or the fact that the child had received two injections of 0.0006 grm. of morphine. Usually he gave only one. All the wounds were sewed up by through-and-through sutures and in all cases this method was satisfactory.

Dr. J. Lockhart Gibson pointed out that in experimental work on dogs through-and-through sutures had proved very satisfactory.

Dr. J. B. McLean said that he had not seen an intussusception in an adult in the course of many hundred acute abdominal conditions.

Dr. D. A. Cameron mentioned that he had once seen a case of chronic intussusception in a boy of eighteen.

Dr. G. P. Dixon, in reply to many questions as to cause, said that he had searched the literature, but could find no satisfactory explanation. He also laid very great stress on the facial appearance and the stage before the appearance of the tumour. He had found the tumour when the intussusception was of a moderate size in nearly every case. It usually meant waiting with the hand on the abdomen for a spasm, but this was quite unmistakable and appeared even under chloroform. He gave an instance of diagnosis from the history and expression in a very early case; the intussusception was only 5 cm. long after five to six hours.

Dr. T. Leckie stated that in this case there had been no spasms of pain.

Dr. W. N. Robertson said he had seen one patient aged 20 and a doubtful case in a patient aged 45.

Dr. G. P. Dixon showed a case of torticollis in a child aged 8. He had divided the right sterno-mastoid and the underlying deep fascia, had forcibly over-corrected the deformity and had applied an extension apparatus for some weeks, followed by vigorous massage. Without the latter

there was a tendency to relapse at once. The child had now good movement. Of the various theories of torticollis he was inclined to favour that of ischaemic paralysis developing *in utero* and producing a condition resembling a Volkmann's contracture. The after treatment was essential and included the correction of any visual errors. In this patient the secondary scoliosis was, of course, still present

Dr. D. A. Cameron insisted on the need for division of the deep cervical fascia as well as the sterno-mastoid. He had no success with simple over-correction.

Dr. J. B. McLean asked what were the possibilities of recurrence and suggested that constant supervision would be necessary. He also asked what measures Dr. Dixon had used for extension.

Dr. Dixon said he had used simple strapping rather than plaster; he had found it most effective.

Dr. S. F. McDonald showed a case of juvenile myxoedema in a girl aged 12 years. She had been a perfectly normal bright child till about 18 months ago, when her mother noticed that she was growing very deaf and stupid, while her weight was increasing. She was also much affected by cold and had a very great appetite for all forms of carbohydrates. There was a slight degree of polyuria, but no carbohydrate intolerance. After six months she weighed 36.7 kilograms and was 127.5 cm. in height. Her figure was much more than of a child with pituitary deficiency, but her mentality was very low, her voice was harsh and there was "solid oedema" of the hands, malar flush and supra-clavicular padding. When in this condition she was shown at the clinical session of the Congress and was looked on as being more of pituitary than thyrotoxic type. On thyrotoxic extract, however, she had improved greatly; her weight had decreased in one month from 36.7 to 31.3 kilograms and her hearing and intelligence had improved to such an extent that she had been able to return to school and was in a class with girls of her own age. She required thyrotoxic extract (0.03 grm.) three times a day. Otherwise she relapsed at once, as was shown recently when she was away on holiday. Her supply of thyrotoxic extract had been exhausted and she had returned dull and sluggish again.

Dr. J. Lockhart Gibson pointed out that the case was one of true sporadic myxoedema, not cretinism, and suggested thyrotoxic transplantation. This was discussed by Dr. D. A. Cameron and Dr. J. B. McLean and it was decided that it should be tried if suitable material were available. There was some doubt expressed as to the immediate effects flooding of the body with thyrotoxic extract, possibly to a dangerous degree.

Dr. McDonald also showed a case of Fröhlich's syndrome, *dystrophia adiposo-genitalis*, in a boy aged 4, a normal child except for a very long and severe labour. He weighed 20 kilograms. There was marked hypertrophy of mammary tissue and genital aplasia. He was unable to walk owing to his great weight and to weakness of his ankles. Mentally he was very bright and active. It was hoped to procure some whole gland pituitary and to try its effect.

Dr. R. H. Mathewson showed a case of plumbic infantilism in a boy aged 14, height 122 cm., weight 23.5 kilograms. He was the eleventh of eighteen children and was quite normal until the age of 18 months, when he had convulsions. He apparently recovered completely till the age of 7, when he had complete lead paralysis and a blue line in the gums. He has been in hospital for a time and had a varying degree of albuminuria. He had always been stunted, mentally and physically. He would not leave his mother nor attend school; he complained of headaches. His eyes were normal. The blood picture is remarkable: Haemoglobin, 67.7% (Sahli); no basophilia; red cells, 3,200,000; leucocytes, 20,000; eosinophilic cells, 40%; polymorphonuclear cells, 22%; large mononuclear cells, 10%; lymphocytes, 23%.

Dr. J. Lockhart Gibson pointed out that there was still a blue line and suggested deionization.

The patient caused much interest. Dr. Anderson commented especially on the absence of basophilia in such a severe case.

Dr. Mathewson said basophilia was not a constant sign. Dr. S. F. McDonald quoted Gordon Ward to the effect that in Germany periodical examinations of workers in lead industries were made, basophilia being present before more severe symptoms.

Dr. D. G. Croll spoke of the very high eosinophilia. He had only seen such a thing in bilharziosis. Another explanation might be filaria. The patient had not been examined for this. The presence of hookworm should also be excluded.

Dr. McDonald said a preliminary examination had shown no ova; another was to be carried out.

Dr. F. C. Bechtel spoke of a case he had seen in practice with 36% eosinophilia and nothing else to be found except enlarged glands and languor. He would try to bring the patient to the next meeting.

Dr. G. P. Dixon discussed the various conditions in which eosinophilia was found and instanced a patient at Rosemont Military Hospital with a 16% eosinophilia and no evidence of any other condition.

Dr. W. N. Robertson said in connexion with eosinophilia in asthma, that the percentage was 9-10 in quiescent cases and 30 during an attack. In those patients in whom nasal treatment was successful, the percentage fell to normal at once. The series comprised some hundreds.

Dr. S. F. McDonald showed on behalf of Dr. J. J. Power a case diagnosed as vesical calculus in a boy of 10. For some months past this child had had a typical history of pain after movement, frequent and precipitate micturition, with increase of pain at the end of the act. The urine constantly contained small amounts of blood. Owing to the extremely fine urethra neither a sound nor the cystoscope could be used. X-ray examination showed a shadow which remained constantly in one position, both when the bladder was full and empty. This suggested a stone lying in a diverticulum of the bladder.

Dr. A. T. Nisbet discussed the X-ray findings. The shadow in its denser centre and thinner periphery was typical of renal calculus; the position was not too high for a vesical calculus. The possibilities of a shadow in this area were practically only two: calculus or calcified gland; the balance was against a gland.

After the X-ray plates had been examined, Dr. McDonald stated that at operation Dr. Power had found the bladder and the bladder wall perfectly normal, but a mass could be felt outside the bladder, above and internal to the ureteral opening. Rectal palpation showed the presence of a body between bladder and rectum, firmly attached to the pelvic wall. It was not considered justifiable at operation either to attempt to open the ureter from the bladder or to extend the operation and look for the ureter through the abdominal wound.

Dr. D. A. Cameron suggested that a double ureter was present. The general opinion was that the condition was one of ureteral calculus.

Dr. T. Leckie (for Dr. Graham Butler) showed a case of *spina bifida* and double talipes in an infant of seven days. The history was vague; it was apparently a full-time baby. Labour had been normal and the family history contained no information of value.

Dr. Dixon thought the outlook very bad and did not consider operation justifiable.

Dr. D. A. Cameron agreed with Dr. Dixon as to the futility of operation. In reply to a question of Dr. Bechtel re treatment of the club-foot, he said that it was quite possible to get feet right by manipulation. To train the mother to manipulate the child's foot was more important than splinting. If fixation were necessary, plaster was as satisfactory as splints and much cheaper. If manipulation were begun at birth, reduction was frequently complete by the time the child was walking.

Dr. G. Croll always advocated manipulation rather than splinting in these cases.

Dr. J. A. Cameron said that he had seen one successful case of operation for *spina bifida*.

Dr. Gifford Croll showed the heart and duodenum from a case of acute rheumatic endocarditis occurring as the outcome of an attack of chorea in a boy aged nine. There was involvement of both mitral and aortic valves and the tricuspid valve was possibly affected. The duodenum showed an ulcer the size of a threepenny piece, with clear sharp edges, extending down to the head of the pancreas. No symptoms had arisen during life, until just before death,

when the patient being very ill and the heart failing continuously, about 280 c.cm. of altered blood were vomited. Dr. Croll considered that the ulceration probably began during infancy.

Obituary.

JOHN MACKENZIE.

It was known by many of his friends that John Mackenzie, of Glen Innes, New South Wales, had been for many years in indifferent health. Few, however, were aware that his life was in danger and the news of his death on July 20, 1921, came as a shock to them all. The sympathy felt and expressed for his relatives, including Dr. A. J. MacKenzie, has been accentuated by the sad fact that nine days after his death his mother passed away.

John MacKenzie was born in 1874, in Aberdeen. His parents came to Australia when he was quite young and settled in Manilla in New South Wales. He was sent to the Sydney High School and from thence he entered the University of Sydney in due course. He graduated at the age of 25 M.B., Ch.M.. Soon after taking his degree he was appointed Resident Medical Officer at the Sydney Hospital. He then went to Sccone, where he practised with the late H. J. H. Scott. In 1906 he was appointed Medical Officer at the District Hospital at Glen Innes. At Glen Innes he rapidly established himself in practice and became immensely popular with a very large section of the population. He was noted for his skill as a practitioner, for his sympathetic bearing and for his unselfishness. He was always prepared to help not only in a strictly professional manner, but without ostentation in other practical ways. He worked long and arduously for the institution to which he was attached and always rendered efficient service to its inmates. A few years ago he was appointed Government Medical Officer in succession to Dr. F. H. Wrigley. The state of his health precluded him from offering his services with the Australian Imperial Force when war broke out, but he was too large-minded a man to be denied the right of serving his country. In 1916 he was appointed Honorary Captain in the Australian Army Medical Corps Reserve and in this capacity performed a great deal of work in the examination of recruits. In 1917 he was transferred to the Australian Army Medical Corps and on October 1, 1919, he was appointed to the Reserve of Officers.

Outside of his profession he had many interests. He was a patron of the Returned Soldiers' League, the Vice-President of the New State League and of the Glen Innes Horticultural Society, President of the School of Arts and Deputy Sheriff of the district. He was on almost every committee of local institutions. During the war period and since he was a member of the Repatriation Committee; in this connexion his knowledge and judgement proved extremely valuable. He was a prominent Freemason and during the course of years held one high office after another up to that of Past Grand District Inspector of Workings. John MacKenzie was held in respect and affection by all those with whom he came in contact, colleagues, patients and friends. There are too few men in the world who are endowed with so many excellent qualities. We can ill afford to lose him.

THE WAR MEMORIAL FUND IN VICTORIA.

The following are the names of additional subscribers to the War Memorial Fund of the Victorian Branch of the British Medical Association: R. D. Aitchison, C. H. Anderson, J. M. Baxter, K. McK. Doig, G. J. A. B. Halford, Frank R. Kerr, S. F. Ridley, C. Gordon Shaw, W. G. H. Tregebar.

We have been informed that the Federal Government has found it imperative to postpone the conference on venereal diseases which was to have been held on September 5, 6 and 7, 1921. The date on which the conference will meet, will be announced later.

The annual meeting and *réunion* of the Society of Returned Medical Officers of New South Wales will be held on August 31, 1921, at 8.30 p.m. at the Ritz Tavern, Elizabeth Street, Sydney. A charge of 3s. 6d. will be made to cover the cost of a "chicken supper." Members intending to be present, are requested to notify the Honorary Secretaries, Dr. Hugh R. G. Poate and Dr. C. E. Wassell, before August 29, 1921.

Proceedings of the Australian Medical Boards.

NEW SOUTH WALES.

The undermentioned have been registered under the provisions of the *Medical Act, 1912* and *1915*, as duly qualified medical practitioners:

Andrews, William Algernon, M.B., Bac. Surg., 1912 (Univ. Melbourne), 149 Livingstone Road, Marrickville.
 Carr, William James, Mem. R. Coll. Surg., Eng., 1908; Lic. R. Coll. Phys., Lond., 1908, Royal Australian Naval College, Jervis Bay.
 Jeffries, James Tatham, M.B., Ch.M., 1921 (Univ. Sydney), Badminton Road, Croydon.
 Thomas, Mervyn Hetherington, M.B., Ch.M., 1921 (Univ. Sydney), Royal Prince Alfred Hospital.

VICTORIA.

The undermentioned has been registered under the provisions of Part I. of the *Medical Act, 1915*, as a duly qualified medical practitioner:

McDonald, John Joseph Laurence, L.R.C.P. et S., Edin., L.R.F.P.S., Glas., 1921, c/o Royal Bank, Collins Street, Melbourne.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xviii.

University of Sydney: Professor of Psychiatry.

Hospital for Sick Children, Brisbane: Resident Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phoenix Mutual Provident Society.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Institutes or Medical Dispensaries. Australian Prudential Association Proprietary, Limited. Manchester Unity Independent Order of Oddfellows. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.)	All Contract Practice Appointments in Western Australia.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington New Zealand.

Diary for the Month.

Aug. 31.—Vic. Branch, B.M.A., Council.
 Sept. 2.—Q. Branch, B.M.A.
 Sept. 7.—Vic. Branch, B.M.A.
 Sept. 8.—N.S.W. Branch, B.M.A.: Last day for nomination of two candidates for election to Federal Committee.
 Sept. 9.—N.S.W. Branch, B.M.A., Clinical.
 Sept. 9.—S. Aust. Branch, B.M.A., Council.
 Sept. 9.—Q. Branch, B.M.A., Council.
 Sept. 13.—Tas. Branch, B.M.A.
 Sept. 13.—N.S.W. Branch, B.M.A.: Ethics Committee.
 Sept. 14.—Melb. Paediatric Society (Vic.).
 Sept. 15.—Vic. Branch, B.M.A., Council.
 Sept. 16.—Central Southern Med. Assoc. (N.S.W.).
 Sept. 20.—N.S.W. Branch, B.M.A.: Executive and Finance Committee.
 Sept. 21.—W. Aust. Branch, B.M.A.
 Sept. 22.—Clinical Meeting at the Hospital for Sick Children, Brisbane.
 Sept. 23.—Q. Branch, B.M.A., Council.
 Sept. 27.—N.S.W. Branch, B.M.A.: Medical Politics Committee: Organization and Science Committee.
 Sept. 28.—Vic. Branch, B.M.A.: Council.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.
 Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.
 All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney. (Telephone: B. 4635.)